

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4709	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/18/2010
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, FT SANDERS			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 HIGHLAND AVE KNOXVILLE, TN 37916		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During the Life Safety Code portion of the licensure survey on October 18, 2010, the NHC Fort Sanders was not cited deficiencies from Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

SKCQ21

TITLE **N.H.A.**

(X6) DATE
11/2/10

If continuation sheet 1 of 1

NOV 02 2010